Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PARK PLAZA HOSPITAL
PATIENT FINANCIAL SERVICES/ CENTRAL
FINANCIAL CONTROL
FRISCO BRANCH
2401 INTERNET BLVD
FRISCO TX 75034

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-04-1376-01

MFDR Date Received
SEPTEMBER 30, 2003

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Carrier remitted $6,579.24 to the provider as reimbursement for outpatient services rendered to the claimant in his pursuit of medical benefits. The carrier, in its explanation of benefits issued states that the first reimbursement of 376.25 was 'made on outpatient bill' then in the second line the carrier then states' reimbursed per negotiated contract with helathnet [sic] plus'. The supplemental reimbursement in the amount of $809.18 accompanied the following explanation; YS supplemental payment; 66 payment consistent with the fee schedule guidelines for reimbursement of multiple surgical procedures performed on the same day. The carrier received information in making the first payment as it did in processing the second. Further carrier cited a guiedline [sic] for outpatient services that simply does not therefore provider seeks the additional reimbursement."

Amount in Dispute: $4,406.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is this carrier's position that a) the requestor failed to produce any credible evidence that its billing for the disputed procedures is fair and reasonable; b) the requester failed to prove its usual and customary fees for the service in dispute is fair and reasonable are consistent with Section 413.011(b); c) this carrier's payment is consistent with fair and reasonable criteria established in Section 413.011(b) of the Texas Labor Code; and d) Medicare fair and reasonable reimbursement for similar or same service is below this carrier's."

Response Submitted by: Texas Mutual Insurance Co., 221 West 6th Street, Ste. 300, Austin, TX 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 22, 2003	Outpatient Hospital Services	$4,406.94	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on September 30, 2003. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on October 14, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - M – No Mar
   - T2 – Reduction was made on outpatient bill.
   - C –Negotiated contract price
   - YC – Reimbursed per negotiated contract with Health Net Plus.
   - O – Denial after reconsideration.
   - YO – Reimbursed was reduced or denied after reconsideration of treatment/service billed.
   - S – Supplemental payment.
   - YS – Supplemental payment.
   - F – Fee guideline MAR reduction
   - 66 – Payment is consistent with the fee schedule guidelines for reimbursement of multiple surgical procedures performed on the same date.

Findings

1. The insurance carrier reduced or denied disputed services with reason code C – "Negotiated contract price." and YC – "Reimbursed per negotiated contract with Health Net Plus." On January 13, 2011, the Division requested a copy of the contract between the informal/voluntary network and Park Plaza Hospital as described by Texas Labor Code §413.011(d-1)(2) and documentation to support that Park Plaza Hospital was notified in accordance with 28 Texas Administrative Code §133.4. The carrier received signed for request on January 18, 2011. The carrier did not respond to the request for additional information; therefore, the above denial/reduction reason is not supported and the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(e)(2)(A), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a copy of all medical bill(s) as originally submitted to the carrier for reconsideration…" Review of the documentation submitted by the requestor finds that the request does not include a copy of the medical bill(s) as submitted to the carrier for reconsideration. The Division concludes that the requestor has not met the requirements of §133.307(e)(2)(A).
5. 28 Texas Administrative Code §133.307(g)(3)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. Although the requestor did submit a copy of the operative report, the requestor did not submit a copy of the anesthesia record, post-operative care record, or other pertinent medical records

sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(B).

6. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 6, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.